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No. 79-92

# In the Supreme Court of the United States

OCTOBER TERM, 1978

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LINCOLN PARK NURSING HOME, ET AL., PETITIONERS

*v.*

UNITED STATES OF AMERICA

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*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS*

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**BRIEF FOR THE UNITED STATES IN OPPOSITION**

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### CITATIONS

Cases:

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### OPINION BELOW

The decision of the United States Court of Claims (Pet. App. 1a-11a) is not yet reported.

### JURISDICTION

The judgment of the Court of Claims was entered on April 20, 1979. The petition for a writ of certiorari was filed on July 18, 1979. The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

### QUESTION PRESENTED

Whether a regulation under the Medicare program that permits the Secretary of Health, Education, and Welfare to recover cost reimbursements paid to a nursing facility on an accelerated depreciation basis when the facility has experienced a substantial decline in the percentage of its Medicare patients is contrary to the Medicare Act or the Due Process Clause of the Fifth Amendment.

## STATUTE AND REGULATION INVOLVED

42 U.S.C. 1395x(v)(1)(A) provides in pertinent part:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or serivces, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance



> programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

20 C.F.R. 405.415(d)(3), 35 Fed. Reg. 12331 (Aug. 1, 1970), provides:

> When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

## STATEMENT

The Medicare Act, 42 U.S.C. 1395 *et seq.*, provides for direct federal payments to nursing homes furnishing care to certain qualified patients. The statute directs the Secretary of Health, Education, and Welfare to reimburse homes for the "reasonable cost" of providing this service and provides that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used * * *." 42 U.S.C. 1395x(v)(1)(A). The statute further requires (*ibid.*) that the regulations "provide for the making of suitable retroactive corrective adjustments where * * * the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

The Secretary's original regulations, which were published at 20 C.F.R. 405.415(a)(3) (1967), allowed reimbursement for the depreciation of capital assets by either of two methods: straight line depreciation (whereby the cost is prorated equally over the useful life of the asset) or accelerated depreciation (whereby the cost is heavily weighted in the initial period of an asset's useful life).

After several years' experience with the administration of the program, the Secretary found that the accelerated depreciation method permitted by the regulations was causing excessive payments to some providers. Accordingly, 20 C.F.R. 405.415(a)(3) was amended on August 1, 1970 (35 Fed. Reg. 12330) to require straight line depreciation for most new assets.[1] The amended regulation also contained a recapture provision, 20 C.F.R.

[1]The amended regulation continues to permit accelerated depreciation for (1) assets being depreciated on an accelerated basis prior to August 1, 1970, (2) assets for which the provider had made an application to change depreciation methods prior to August 1, 1970,



405.415(d)(3), which provides that when a provider who had used accelerated depreciation terminates participation in the program, or when the health insurance portion of its allowable costs decreases to the point that substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the difference between the depreciation that was paid and that which would have been paid using the straight-line method "will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment."

Petitioners have provided nursing services to the public since January 1, 1967. They participated in the Medicare program and, pursuant to the regulatory option initially permitted, were reimbursed for reasonable costs on the basis of accelerated depreciation. In 1974, HEW's fiscal intermediary determined (in a ruling constituting the final administrative decision; see Pet. App. 3a-4a) that from 1967 through 1971 petitioners received excessive reimbursement resulting from their use of accelerated depreciation and a substantial decrease in the percentage of their patients eligible under the Medicare Act (*id.* at 2a-4a).

Petitioners then filed suit in the Court of Claims to recover the costs attributable to the accelerated depreciation that had been disallowed.[2] The court granted the

(3) assets for which the provider had no option to use straight-line depreciation prior to August 1, 1970, (4) assets for which construction began prior to February 5, 1970, and (5) assets which the provider was bound by contract to purchase prior to February 5, 1970. See 20 C.F.R. 405.415(a)(3).

[2]Petitioners previously had filed suit in the United States District Court for the District of New Jersey, but that court held that it had no jurisdiction and dismissed the suit without prejudice to petitioners' right to bring another action in the Court of Claims. The court of appeals affirmed (Pet. App. 4a n.4).

government's motion for summary judgment, rejecting petitioners' claims that the recapture of reimbursements for accelerated depreciation for the years 1967-1970 is unconstitutional and contrary to the Medicare statute. Relying on its prior decision in *Summit Nursing Home* v. *United States*, 572 F. 2d 737 (Ct. Cl. 1978), the court held that the recapture of accelerated depreciation in this case was reasonable and consistent with the Secretary's express statutory obligation to recover excessive reimbursements and to ensure that the Medicare program not pay the costs of non-Medicare patients (Pet. App. 5a).

## ARGUMENT

The decision of the Court of Claims is correct and does not warrant review by this Court. Moreover, the issue involved here is not of general or recurring importance, because the Secretary's recapture regulation concerns only the problems associated with the 1970 change in Medicare accounting from an accelerated depreciation system to a straight line depreciation system.

1. Petitioners claim (see Pet. 2) that applying the recapture regulation to reimbursements paid to them for accelerated depreciation before the recapture regulation was adopted is unconstitutional and contrary to the statutory design. These claims are insubstantial.

Petitioners' statutory argument is foreclosed by the express terms of the Medicare Act. 42 U.S.C. 1395x-(v)(1)(A) vests the Secretary with the responsibility for promulgating regulations governing Medicare cost accounting. It also requires the Secretary to ensure in those regulations that "the costs with respect to individuals [covered by the insurance programs established by this subchapter] will not be borne by such insurance programs" and to "provide for the making of suitable



*retroactive* corrective adjustments where * * * the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive" (emphasis supplied). Section 405.415(d)(3) was promulgated to carry out these directives. It is a reasonable means of accomplishing those ends and as such it is expressly authorized—indeed, mandated—by the statute.

As we have noted (see pages 4-5, *supra*), the regulations initially allowed providers to use accelerated depreciation. In 1970, however, the Secretary concluded that accelerated depreciation was not an appropriate method of Medicare accounting and prospectively barred its use (Pet. App. 4a-5a). The 1970 regulation also dealt with the transitional problem relating to providers who had already started to depreciate assets on an accelerated basis. The Secretary concluded that in general such providers would be permitted to continue to write off those assets using accelerated depreciation. See 20 C.F.R. 405.415(a)(3); note 1, *supra*. In cases where the ratio of a facility's Medicare to non-Medicare patients remains fairly constant, the high reimbursement in the initial years of the accelerated depreciation of assets allocable to Medicare patients is offset in later years by a countervailing low cost recovery for those assets, and the result in the long run is ordinarily much the same as with straight line depreciation. However, when the percentage of a facility's Medicare patients decreases substantially before the assets have been completely depreciated, use of accelerated depreciation allows the facility to obtain a

windfall.[3] The Secretary reasonably concluded that this result would be contrary to his statutory obligation not to permit the Medicare program to subsidize the costs of non-Medicare patients. See *Summit Nursing Home*, v. *United States*, 572 F. 2d 737, 744 (Ct. Cl. 1978).

Although petitioners appear to contend that application of the recapture regulation is unfair, they offer no arguments either disputing the Secretary's conclusion that the regulation reasonably operates to recover excessive reimbursements or supporting their claim that it is contrary to the statutory scheme. Moreover, petitioners entered the Medicare program on notice that the statute authorized and directed the Secretary to make "suitable retroactive adjustments" with respect to reimbursements that proved to be excessive.[4]

Similarly, there is no merit to petitioners' claim that application of the recapture regulation (and presumably the statute authorizing it) is unconstitutional. "[L]egislation readjusting rights and burdens is not unlawful solely because it upsets otherwise settled expectations." *Usery* v.

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[3]For example, suppose a facility purchased for a Medicare patient a bed with an estimated 10-year life and under some method of accelerated depreciation the Secretary reimbursed the facility for 70% of the cost of the bed in the first three years. If the bed were used by a Medicare patient for only the first three years and by a non-Medicare patient for the next seven years, the facility would receive and retain a disproportionate and excessive reimbursement for its Medicare-related costs in the absence of a recapture provision.

[4]Accord, *Adams Nursing Home* v. *Mathews*, 548 F. 2d 1077 (1st Cir. 1977); *Fairfax Nursing Center, Inc.* v. *Califano*, 590 F. 2d 1297 (4th Cir. 1979); *Springdale Convalescent Center* v. *Mathews*, 545 F. 2d 943 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital*, 543 F. 2d 703 (9th Cir. 1976), vacated on other grounds, 430 U.S. 952 (1977).



*Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976). See, also *Fairfax Nursing Center, Inc.* v. *Califano*, 590 F. 2d 1297, 1302 (4th Cir. 1979); *Adams Nursing Home* v. *Mathews*, 548 F. 2d 1077, 1080-1083 (1st Cir. 1977). It was not improper for the Secretary to take steps, expressly authorized by statute, to limit their windfall recovery at public expense.

2. Petitioners rely primarily (Pet. 8-11) on *Daughters of Miriam Center For The Aged* v. *Mathews*, 590 F. 2d 1250 (3d Cir. 1978) (reproduced at Pet. App. 12a-46a), in which the court refused to apply the recapture regulation to a nursing home in circumstances somewhat similar to this case. Although we believe that *Daughters of Miriam Center* was wrongly decided, there are important differences between the two cases and the conflict, if any, is a narrow one of little continuing importance.

In *Daughters of Miriam Center*, the Secretary sought to recapture pre-1970 accelerated depreciation reimbursements because in several post-1970 years the home had experienced a substantial but temporary decline in the percentage of its Medicare patients as a result of the Secretary's having promulgated more stringent patient-eligibility requirements in 1971. The court of appeals, with one dissent, concluded that in those circumstances recapture of pre-1970 accelerated depreciation payments would not be sufficiently in furtherance of the purpose of the statute and regulation to outweigh what the court felt would be unfair prejudice to the home (Pet. App. 27a-41a), which had "justifiably and materially relied" on the prior regulation (*id.* at 41a). The court stressed, however, that its "holding is a narrow one" based on the particular facts of that case (*id.* at 40a). Thus, it agreed that recapture of pre-1970 accelerated depreciation reimbursements would be proper with respect to nursing homes that had completely terminated or voluntarily reduced their Medicare participation or that (unlike the

home in that case) did not subsequently increase their participation to previous levels (*id.* at 35a-38a). It also conceded that, even in the situation posed by the Daughters of Miriam Center, recapture served some public interest (*id.* at 38a). Finally, the court expressly declined to address the constitutional claims advanced by the nursing home (*id.* at 41a).

Although we believe that the Third Circuit erred in concluding that recapture was unfair in that case and improperly substituted its judgment for the Secretary's with respect to whether the regulation served the public interest, the decision (as noted above) was confined to its facts. Here, petitioners do not claim that their reduction in Medicare participation was only temporary or that it resulted from the 1971 change in patient-eligibility standards. Instead, they explain (Pet. 4-5) that the reduction resulted from difficulties they were experiencing with the fiscal intermediary, which apparently led petitioners to conclude that Medicare participation was not sufficiently remunerative. Hence, they would not be entitled to relief even under the Third Circuit's approach. In any event, the conflict, if any, between this case and *Daughters of Miriam Center* relates to a non-recurring problem arising from a change in Medicare accounting methods in 1970 and is not sufficiently important to warrant this Court's review.



## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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